Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
RGOI AMBULATORY SURGERY CENTER
5520 NORTH C STREET
MCALLEN TX 78504

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TPS JOINT SELF INS FUNDS

Carrier's Austin Representative Box
Box Number 11

MFDR Tracking Number
M4-05-9364-01

MFDR Date Received
DECEMBER 12, 2001

REQUESTOR'S POSITION SUMMARY

Requestor's Documentation: None found/provided

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None found/provided

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2000	Ambulatory Surgical Services	$7,302.70	$0.00

Background

1. Former 28 Texas Administrative Code §133.305 adopted to be effective June 3, 1991, 16 Texas Register 2830, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. Former 28 Texas Administrative Code §102.5, adopted to be effective July 29, 1991, 16 *Texas Register* 3939; amended to be effective March 15, 1995, 20 *Texas Register* 1418, sets out the guidelines for written communications from the Division, formerly the Commission.
5. Former 28 Texas Administrative Code §133.305, 16 Texas Register 2830, effective June 3. 1991, section (j) sets out the procedures for the Division to request additional information from the parties.

Finding

Existing records indicate that the Medical Fee Dispute Resolution (formerly medical review) program docketed a request for medical fee dispute resolution as described in the *General Information* section above. On June 29, 2012, the parties in dispute were notified that the division was unable to locate the physical documentation associated with the aforementioned dispute. This notice was made in the form of a letter which was sent to:

(1) the requestor via regular mail to the address listed above;
(2) the respondent via its Austin representative box as listed above.

The division, as required by 28 TAC §102.5 (e) effective for the dates of service in dispute, relied upon information supplied by the requestor or health care provider, and all its known representatives for delivery of the letter. Similarly, the division relied upon the information supplied by the respondent for delivery of the letter to its appropriate Austin carrier representative as required in 28 TAC §102.5 (b).

The letter to the parties included a request for copies of: (1) the original request for dispute resolution; (2) additional information; (3) copies of correspondence; and (4) any additional documentation or information the parties saw fit to provide. Additionally, the party providing documentation was instructed to forward a copy to all other parties at the time it was provided to the division. To date, the division has no record of receiving any responsive documentation from the respondent, requestor, nor from any representatives of the requestor.

Former 28 Texas Administrative Code §133.305(j), 16 Texas Register 2830, effective June 3, 1991, states that "The commission may request additional information from either party to review the medical issues in the dispute. Requested information shall be forwarded to the division of medical review at the commission within 10 days of receipt of request. The Division requested additional information from the insurance carrier, with a copy of the request to the health care provider on May 31, 2012; however no documentation was provided by either party. Consequently, the Division finds that the requestor has failed to support its request for additional reimbursement.

Conclusion

The division concludes that the requestor has not supported its request for additional reimbursement. For that reason, no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 10, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.